Main Site: 31 Alexandra Road
Reading
Berkshire
RG1 5PG

Tel: 0118 9352121
Fax: 0118 9359420

Branch Site: 9 Eldon Square
Reading
Berkshire
RG1 4DP

Tel: 0118 9574891
Fax: 0118 9552955

Dr. Gerard D'Cruz
Dr. Jude D'Cruz
Dr. Paula Indaco

Travel Risk Assessment Form

Please complete this form and return it to the surgery **prior to your travel appointment.**

PERSONAL DETAILS

Name:		Today's date:
Male ☐ Female ☐	Date of Birth:	Easiest contact Tel. No.
Email:		

ITINERARY and DATES

Departure date: (From UK)	Return date: (To UK)	
Country to be visited (Including stopovers)	Length of stay	In an emergency, how long will it take to get medical help?
1.		
2.		
3.		

PURPOSE OF VISIT (Circle the words that best describe your trip)

1. Type of trip	*Business*	*Pleasure*	*Other*
2. Travel to destination	*Aeroplane* *Train*	*Boat* *Bus*	*Car* *Other*
3. Holiday type	*Package* *Camping* *Other*	*Self-organised* *Cruise ship*	*Backpacking* *Trekking*
4. Accommodation	*Hotel* *Other*	*Relatives*	*family home*
5. Travelling	*Alone*	*With family/friend*	*In a group*
6. Staying in area which is:	*Urban* *Coast*	*Rural*	*At Altitude*
7. Planned activities	*Safari*	*Adventure*	*Other*

On site facilities include Endoscopy, Diagnostic Ultra-sound, Minor Surgery & Phlebotomy
See our website for more details **www.pembrokesurgery.com**

PERSONAL MEDICAL HISTORY

Please list any recent or past medical history of note:
(This includes diabetes, heart or lung conditions, thyroid disorder, splenectomy, high blood pressure.)

List any current or repeat medications:

Please list any allergies?
(e.g. eggs, antibiotics, nuts)

Question	YES	NO
Have you ever had a serious reaction to a vaccine in the past?	☐	☐
Does having an injection make you feel faint?	☐	☐
Do you or any close family member have epilepsy?	☐	☐
Do you have any history of mental illness including depression or anxiety?	☐	☐
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?	☐	☐
Women only: Are you pregnant or planning pregnancy or breast feeding?	☐	☐
Women only: Are you on the hormonal contraceptive pill?	☐	☐
Have you taken out travel insurance?	☐	☐
If you have a medical condition, have you informed the insurance company about this?	☐	☐

Please give any further information that may be relevant, including any future travel plans:

VACCINATION HISTORY

Please give the dates when you had any of the following vaccinations:

Vaccination	Date	Vaccination	Date
Tetanus		*Hepatitis A*	
Diptheria		*Hepatitis B*	
Polio		*Typhoid*	
Meningitis		*Rabies*	
Yellow Fever		*Jap B Enceph*	
Tick Borne Enceph		*Influenza*	
Other:			

Which malaria tablets have you used in the past:

Are there any questions you would like to discuss?

FOR OFFICE USE

Patient Name:

Travel risk assessment performed Yes ☐ No ☐

Travel vaccines recommended for this trip

Disease protection	Yes	No	Further Information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diptheria			
Polio			
Meningititis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Tick Borne Encephalitis			
Other			

Travel advice and leaflets given:

Food, water & personal hygiene ☐ Travellers diarrhoea ☐ Hepatitis B, C & HIV ☐
Insect bite prevention ☐ Animal bites ☐ Accidents☐ Insurance☐
Air travel ☐ Sun & heat prevention ☐ Hajj travel ☐
Travel record card supplied ☐ Websites ☐ Follow up required ☐
Other

Malaria prevention advice & malaria chemoprophylaxis:

Chloroquine & proguanil ☐ Atovaquone + proguanil (Malarone) ☐
Chloroquine ☐ Mefloquine ☐ Doxycycline ☐
Malaria advice leaflet☐
Further information e.g. weight of child

Signed by: Position: Date:

PATIENT SIGNATURE

I have no reason to think that I might be pregnant. I have received information on the risks & benefits of the vaccines recommended & have had the opportunity to ask questions. I consent to the vaccines being given.

Signed: **Date:**